

**MONKEY  
MOUTHS**

**pediatric therapy**

Occupational Therapy Child History Form

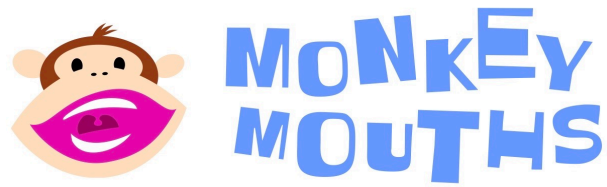
Date: \_\_\_\_\_  
Child's Name: \_\_\_\_\_  
Child's Age: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Parent's Name: \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Email: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Child's Address: \_\_\_\_\_  
Child's Doctor: \_\_\_\_\_  
Sisters and Brothers in the household:  
Name: \_\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of the person completing this form: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_

**STATEMENT OF THE PROBLEM:**

Reason for referral:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the problem:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**pediatric therapy**

Is this the first OT evaluation for your child? Yes No  
If not, who else has seen this child? (Who , When, Outcome)

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What skills do you hope your child will gain if therapy is warranted? What does your child want to learn to do that they currently can't?

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**MEDICAL HISTORY:**

Were there any problems during pregnancy, birth or delivery? Yes No  
If so, please explain:

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Was your child born prematurely? Yes No  
If yes, at how many weeks? \_\_\_\_\_

Is there any history of medical concerns? Yes No  
Please describe any medical concerns, injuries, illnesses, or surgeries:

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Has hearing been tested? Yes No  
Where? \_\_\_\_\_  
When? \_\_\_\_\_  
Results \_\_\_\_\_  
\_\_\_\_\_



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Has vision been tested? Yes No

Wears Glasses: Yes No

Where? \_\_\_\_\_

When? \_\_\_\_\_

Results \_\_\_\_\_

\_\_\_\_\_

Please list any medications your child is currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### DEVELOPMENTAL MILESTONES

Age child began to roll: \_\_\_\_\_

Age child sat unsupported: \_\_\_\_\_

Age child walk / ran: \_\_\_\_\_

Age child began to ride a tricycle/bike: \_\_\_\_\_

Age child began to feed themselves finger foods: \_\_\_\_\_

Age child began to use feeding utensils: \_\_\_\_\_

Age child began to use writing utensils (colors/pencils) \_\_\_\_\_

Briefly describe your child's ability to:

Participate in age level self-care skills (items can include dressing, feeding, grooming, buttons and shoe tying): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Participate in age level eye-hand coordination tasks (items can include sports participation, handwriting abilities and scissoring): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Monkey Mouths**  
1809 Precinct Line Rd.  
Hurst, TX 76054

**Monkey Mouths Too**  
370 S State Hwy 121 Ste. 105  
Coppell, TX 75019

**Monkey Mouths FW**  
7217 Hawkins View Dr Ste. 201  
Fort Worth, TX 76132



Participate in school related activities (reading, spelling, math): \_\_\_\_\_

\_\_\_\_\_

Any current school environment modifications? \_\_\_\_\_

\_\_\_\_\_

Briefly describe any behavior problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Briefly describe any fine motor concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Briefly describe any gross motor concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child been evaluated by other professionals (i.e. Speech Therapy, Physical Therapy, Psychology, etc.)? Yes      No

If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INTEREST INVENTORY:**

What are your child's interests and favorite activities?

\_\_\_\_\_

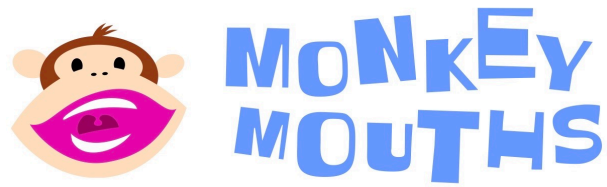
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Does your child have any fears or sensitivities to sensory stimuli (i.e. lights, loud noises, textures)?

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Does your child receive special help in school? Yes No  
If so, please explain:

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Is there anything else you wish to add that would help insure a positive testing experience for your child?

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Is there any additional information or concerns that would help us to get to know your child better?

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Thank you very much for your help and for the information you provided in this case history form. If you have questions before your intake or diagnostic appointments, please contact us at (817) 479-7019.

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